STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	04/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Recertification and State licensure survey. Survey date: April 11, 12, 13, 16 17 and 18, 2012 Facility number-000007 Provider number-155019 AIM number-100275040 Survey team: Marla Potts, RN, TC Sharon Whiteman, RN Amy Wininger, RN (April 16, 17 and 18, 2012) Census bed type: SNF: 16 SNF/NF: 183 Total: 199 Census payor type: Medicare: 26 Medicaid: 128 Other: 45 Total: 199 Sample: 30 Theses deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed 4/19/12 Cathy Emswiller RN			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review the facility failed to ensure interventions for safety were implemented during a shower, by CNA #1 and CNA #2, for Resident #130, in that the resident was not transferred with a full body lift during a shower as outlined in the plan of care and leg sleeves were not on during the shower, for 1 of 7 residents observed to be transferred by staff members, in the sample of 30. Findings include: Resident #130 was identified on the initial tour of the facility, by the Unit Manager on 4/11/12 at 9:30 A.M., as cognitively impaired and dependant for care. The Unit Manager provided the CNA (Certified Nursing Assistant) assignment sheets, at this same time, dated 4/10/12, which indicated skin sleeves when up, tubular (leg sleeves) to lower legs at all times...never turn by using arms...draw sheet between resident and sling when transferring...full body lift at all times, assist times 2.	F0282	Garden Villa's policy is to have services provided or arranged by qualified persons in accordance with each resident's written plan of care. Garden Villa submits the following as evidence of its commitment to compliance with regulatory compliance.I. Describe what the facility did to correct the deficient practice for each resident cited in the deficiency. Resident #130 had been identified by nursing assessment as a high risk transfer. The transfer requirement for this resident was written on the certified nursing assignment sheet. The certified nursing assistant whom failed to comply with directives was terminated. This termination was also based on previous re-education that was received by this employee. Upon review of resident's care plan and condition it was determined that the current interventions are still the safest mode of transfer.II. Describe how the facility reviewed all residents in the facility who could be affected by the same deficient practice, and state what actions the facility took to correct the deficient practice for any resident the facility identified as being	05/07/2012

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	During interview, on 4/16/12 at 9:15 A.M., Unit Manager #3, indicated Resident # 130 was in the shower room getting a shower. Resident #130 was observed in the shower room with CNA #1 and CNA #2. The resident was observed to have been sitting in the wheelchair with no clothes on. A full body lift pad was observed under the resident. CNA #1 took bandage scissors and cut off gauze dressing from both legs. The resident was observed to have a skin tear with steri-strips in place to her right leg, and a skin tear to her hand. CNA #1 told CNA #2 to get under Resident #130's arms and the CNA's proceeded to lift the resident up to transfer her to the shower chair. CNA #1 lifted the resident and pulled her from CNA #2's reach, they both grabbed for the resident with the residents knees observed to bend and her lower legs touch the floor. The CNA's were able to place the resident in her wheelchair by grabbing at the resident's back and arms. The resident was observed to have a red place on her right outer breast and was heard to whimper during the transfer. CNA #1 told the resident "sorry." After the shower was completed, CNA #1 told CNA #2 to hold the wheelchair and		affected. All facility residents have the potential to be affected. In Service training was done with all nursing staff regarding following care plans as directed. *Describe the steps or systemic changes the facility had made or will make to ensure the deficient practice does not recur, including any in-services, but this also should include any system changes you made.* Education will be completed with all new staff during orientation and will continue throughout the length of their employment regarding following care plans as directed. Education has been completed with all nursing staff regarding following care plans as directed. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Audits will be completed on 50 residents per week to assure that care plans are being followed as directed by nursing administration for at least a 3 month period.Director of Nursing and ADON will ensure that education will be completed with all nursing staff during orientation and then regularly on following care plans as directed.Quality Assurance will be	

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	he would transfer the resident. A bath blanket was placed over the full body sling which was left in the wheelchair. CNA #1 placed his arms around the resident and with his arms under the resident's arms lifted the resident and shook the resident's bottom to get the shower chair moved, then placed her into the wheelchair. CNA #2 took the resident to her room and alerted the nurse so new dressings could be applied to her legs. On 04/16/12 at 9:45 A.M. LPN #1 indicated the resident's skin was very fragile and she should always be lifted using the whole body lift only. Resident #130's clinical record was reviewed on 4/15/12 at 11:00 A.M. Diagnoses included but were not limited to: " degenerative osteoporosis." The most recent minimum data set assessment, dated 3/6/12, indicated the resident was severely cognitively impaired and required extensive assistance of two staff members for transfers and hygiene. The care plan included a problem, dated 7/1/09 and updated through 6/2012, for "potential for fractures related to osteoporoses." Diagnosis/approaches included "staff to be extra careful during transfers and activities of daily living to		given a report monthly regarding education. This will be for 3 consecutive months then reviewed for reporting change.*Date of completion* May 7, 2012	

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	avoid possibility of fractures." Another problem, dated 6/29/11 and updated through 6/12, included "requires full body mechanical lift with 2 assist." Approaches included "transfer to be provided with full body lift and 2 assist." Another problem, dated 3/15/11 for "potential for impaired skin integrity/pressure ulcer related to ...fragile skin..." Approaches included; "leg sleeves on at all times, do not remove for showers until after transferred to shower chair, skin tears on 4/12 and 4/15/12." 3.1-35(g)(2)			

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F0314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to ensure a resident who was admitted with pressure did not develop pressure and when pressure developed the facility failed to ensure the resident was repositioned in a manner that off loaded pressure to the coccyx for 1 of 14 sampled residents reviewed for pressure ulcers, in a facility sample of 30 in that, the resident was admitted with a stage I, pressure area-red coccyx, which worsened to a stage IV wound to the coccyx. Resident #57. Findings include: The clinical record of Resident #57 was reviewed on 04/17/12 at 2:15 P.M. The record indicated the diagnoses for Resident #57 included, but were not limited to, CVA [Cerebrovascular Accident] (stroke). The record further	F0314	Garden Villa's policy is to ensure that a resident who enters the facility without pressure areas does not develop pressure areas unless the individual's clinical condition demonstrates that they were unavoidable, and that a resident with pressure area(s) receives the necessary care and treatment to promote healing, prevent infection, and prevent additional pressure areas from developing. Garden Villa submits the following as evidence of its commitment to compliance with regulatory compliance. *Describe what the facility did to correct the deficient practice for each resident cited in the deficiency.* Resident #57 was admitted on 3/24/12 with a diagnosis s/p fall with rib fracture and RLE tramatic radiculopathy realted to fall at home. Resident #57 had a history of previous CVA. Resident #57 had documented low Albumin and Total protein while in the hospital and was being treated for a	05/07/2012

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	indicated, Resident #57 had been admitted on 03/24/12. During the initial tour on 04/11/12 at 9:30 A.M., the Unit Manager #2 identified Resident #57 as having an unstageable wound on the coccyx. Resident #57 was observed on 04/16/12 at 10:50 A.M. lying in bed with his shoulders tilted to the left and his buttocks on the bed. The wife and daughter of Resident #57 were observed at the bedside at that time. During an interview with the spouse of Resident #57, at that time, she stated, "They don't always turn him every two hours." The spouse further indicated she had been at the resident's bedside for about 20 minutes. Resident #57 was observed on 04/16/12 at 11:50 A.M. lying in bed with his shoulders tilted to the left and his buttocks on the bed. The wife and daughter of Resident #57 were observed at the bedside at that time. During an interview at that time, both indicated his position had not been changed since their arrival. Resident #57 was observed on 04/16/12 at 1:45 P.M. lying in bed with his shoulders		pressure area in addition to his injuries. Upon admission to Garden Villa resident #57 was placed on a pressure reduction mattress, Xenaderm ordered and was assessed to have a dark, red area on the coccyx. Family reported that no definitive diagnosis could be made at the hospital to explain why resident had a decline from baseline at home. From admission to this date resident has remained confused and dependent on staff for most all ADL's even with physical and occupational therapies involvment. Resident #57's coccyx was suspected to have deep tissue damage from admission so assessments and interventions were implemented by nursing, dietary and therapy. To address positioning concerns all staff caring for resident #57 were checked off on proper positioning techniques. Hourly documentation was implemented to verify resident #57 was repositioned timely. *Describe how the facility reviewed all residents in the facility who could be affected by the same deficient practice, and state what actions the facility took to correct the deficient practice for any resident the facility identified as being affected.* All residents have the potential to be affected by the same deficient practice. All nursing staff will be inserviced on proper positioning. Describe the steps or systemic changes the	

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	tilted to the right and his buttocks on the bed. Resident #57 was observed on 04/16/12 at 2:55 P.M. lying in bed with his shoulders tilted to the right and his buttocks on the bed. Resident #57 was observed on 04/17/12 at 9:06 A.M. lying in bed on his back. Resident #57 was observed on 04/17/12 at 10:10 A.M. lying in bed on his back. During an observation of care on 04/17/12 at 11:10 A.M. CNA #5 and CNA #6 were observed to reposition Resident #57 to his right side. CNA #5 was observed the prop the resident's upper body with pillows, allowing the buttocks to remain in contact with the bed. In an interview with CNA #5, at that time, she indicated Resident #57 was to be turned and repositioned every hour. Resident #57 was observed on 04/17/12 at 12:15 P.M. to be lying in bed with his shoulders tilted to the right and his buttocks on the bed. At that time, the spouse and daughter were observed to be at the resident's bedside. Both indicated, at that time, the resident's position had not been changed.		facility had made or will make to ensure the deficient practice does not recur, including any in-services, but this also should include any system changes you made.All Nursing staff will be inserviced on proper positioning techniques. Nursing administration will audit 100% of residents with pressure areas at least three times a day for proper positioning techniques and every shift by the charge nurse responsible for that resident's care. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place. Positioning audits will be done for three months and reviewed in Quality Assurance monthly. After three months the audits will be reviewed for a reporting change.*Date of completion* May 7, 2012	

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	Resident #57 was observed on 04/17/12 at 2:00 P.M. to be lying in bed with his shoulders tilted to the right side and his buttocks on the bed. During an interview, at that time, the spouse of Resident #57 indicated the physician had just left and the resident had been repositioned back to his right side when the physician was finished. During an observation of care on 04/18/12 at 9:05 A.M. Resident #57 was observed to be lying in bed. During an interview at that time, CNA #3 and CNA #4 indicated they were repositioning the resident to his left side. CNA #3 then indicated the procedure was complete. At that time, Resident 357 was observed to be lying in bed with his shoulders tilted to the left and his buttocks on the bed. In an interview with LPN #2 on 04/17/12 at 2:40 P.M. she identified herself as the nurse who completed the admission skin assessment. She indicated she observed the area on the coccyx upon admission and stated, "it was very dark red, but not open." She further stated, "just looked like a lot of pressure". The Initial Wound Visit/Re-evaluation dated 04/10/12 indicated the resident experienced an" o/a [open area] coccyx/buttocks...aggravated by			

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	pressure..." The Wound Progress Note/Reassessment dated 04/17/12 indicated the coccyx wound was a Stage IV pressure wound which measured 6.0 X 5.0 X 2.0 with a wound bed of 70% fibrin/slough and 30% necrotic tissue that was deteriorating and required debridement. The Medication Administration Report from [name of hospital] dated 03/22/12 to 03/23/12 indicated the resident was being treated at the hospital with Xenaderm [a topical skin[protectant] for a reddened coccyx. A hospital document dated 03/21/12 was provided by the Unit Manager, #2 on 04/17/12 at 2:30 P.M. indicated Resident #57 had a Stage 1 area on his coccyx and "area is pink but it blances [sic]. Xenederm[sic] to be ordered, and PUP [Pressure Ulcer Prevention] plan of care." The Admission Nursing Assessment dated 03/24/12 at 12:30 P.M. lacked any documentation of skin condition. The assessment included a sketch of a body with a handwritten note over the area of the coccyx that indicated, "dark red". A Nursing Note dated 03/24/12 at 12:30 P.M. indicated, "...Skin assessment			

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	completed [sic]. Noted bil [bilateral] inner buttocks red..." A Nursing Note dated 03/31/12 at 9:15 A.M. indicated, "Previously noted dark red area gluteal crease/butt is now dark purple with 4 separate open areas. All 4 [four] are clean, beefy red wound beds with mod [moderate] amt [amount] bl [bloody] drainage, surrounding tissue is deep purple...staff informed to turn et [and] reposition q 1 [every one hour] while in bed..." A Wound Report indicated a DTD [Deep Tissue Damage] on the gluteal crease related to pressure measured 5.0 X 5.0 X 0.0 and began on 03/31/12. The report further indicated on 04/09/12 the wound deteriorated to a Stage IV [four] and measured 6.0 X 6.0 X not measurable with 100% black eschar present. The Wound Risk Assessment dated 03/25/12 Section 2 question 10 lacked any documentation the resident had a history of or current was experiencing a Stage I-IV pressure wound. The assessment indicated the resident was a high risk for pressure The most recent Wound Risk Assessment dated 04/04/12 indicated the resident was a "very high risk" for pressure.			

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	The Wound Protocol...Protocols Initiated based on Wound Risk Assessment dated 03/31/12 included, but was not limited to, "...turn and reposition every 1 [one] hour..." A plan of care dated 03/31/12 for "pressure ulcer...gluteal crease" included, but was not limited to, an intervention of "T & R [turn and reposition] q 1 hour while in bed..." The most recent MDS [Minimum Data Set Assessment] dated 03/31/12 indicated Resident #57 was severely cognitively impaired, required extensive assist of two staff for bed mobility, had 5 unhealed areas of unstageable pressure ulcers with suspected deep tissue injury in evolution that were not present on admission. The policy and procedure for Prevention of Pressure Ulcers provided by the HFA [Health Facility Administrator on 04/18/12 at 10:30 A.M. indicated, "General Information Relative to Pressure Ulcers: Pressure ulcers are usually formed when a resident remains in thee same position for an extended period of time causing increased pressure or a decrease of circulation(blood flow) that area, which destroys the tissues... Pressure ulcers are often made worse by continual pressure.."			

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	3.1-40(a)(1) 3.1-40(a)(2)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to ensure interventions for safety were implemented during a shower in that Resident #130 was not transferred with a full body lift during a shower as outlined in the plan of care and leg sleeves were not on during the shower, for 1 of 7 residents observed to be transferred by staff members, in the sample of 30. Findings include: Resident #130 was identified on the initial tour of the facility, by the Unit Manager on 4/11/12 at 9:30 A.M., as cognitively impaired and dependant for care. The Unit manager provided the CNA (Certified Nursing Assistant) assignment sheets, at this same time, dated 4/10/12, which indicated skin sleeves when up, tubular (leg sleeves) to lower legs at all times...never turn by using arms...draw sheet between resident and sling when transferring...full body lift at all times, assist times 2.	F0323	Garden Villa's policy is that the residents' environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Garden Villa submits the following as evidence of its commitment to compliance with regulatory compliance.Describe what the facility did to correct the deficient practice for each resident cited in the deficiency. All nursing staff that provides care for resident #130 regularly has been checked off on proper technique for transferring resident in/out of shower by nursing administration.Describe how the facility reviewed all residents in the facility who could be affected by the same deficient practice, and state what actions the facility took to correct the deficient practice for any resident the facility identified as being affected. All residents have the potential to be affected by this practice. Education has been completed with all staff regarding following care plans as directed.Describe the steps or systemic changes the facility had made or will make to ensure the	05/07/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	04/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	During interview, on 4/16/12 at 9:15 A.M. the Unit Manager indicated Resident # 130 was in the shower room getting a shower. Resident #130 was observed in the shower room with CNA #1 and CNA #2. The resident was observed to have been sitting in the wheelchair with no clothes on. A full body lift pad was observed under the resident. CNA #1 took bandage scissors and cut off gauze dressing from both legs. The resident was observed to have a skin tear with steri-strips in place to her right leg, and a skin tear to her hand. CNA #1 told CNA #2 to get under Resident #130's arms and the CNA's proceeded to lift the resident up to transfer her to the shower chair. CNA #1 lifted the resident and pulled her from CNA #2's reach, they both grabbed for the resident with the residents knees observed to bend and her lower legs touch the floor. The CNA's were able to place the resident in her wheelchair by grabbing at the resident's back and arms. The resident was observed to have a red place on her right outer breast and was heard to whimper during the transfer. CNA #1 told the resident "sorry." After the shower was completed, CNA #1 told CNA #2 to hold the wheelchair and he would transfer the resident. A bath		deficient practice does not recur, including any in-services, but this also should include any system changes you made. Education will be completed with all new staff during orientation and will continue throughout the length of their employment regarding following care plans as directed. Education was completed with all nursing staff on following care plans as directed. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place. Audits will be completed on 50 residents per week to assure care plans are being followed as directed by nursing administration for at least a 3 month period.Two times a week care for resident #130 will be observed by nursing administration to assure care plan is being followed as directed for at least a 3 month period.The Director of Nursing, or designee, will report monthly to Quality Assurance regarding check off's for proper transferring technique and following care plans as directed for 3 consecutive months then will review for reporting change.*Date of completion* May 7, 2012	

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	blanket was placed over the full body sling which was left in the wheelchair. CNA #1 placed his arms around the resident and with his arms under the resident's arms lifted the resident and shook the resident's bottom to get the shower chair moved, then placed her into the wheelchair. CNA #2 took the resident to her room and alerted the nurse, so new dressings could be applied to her legs. On 04/16/12 at 9:45 A.M. LPN #1 indicated the resident's skin was very fragile and she should always be lifted using the whole body lift only. Resident #130's clinical record was reviewed on 4/15/12 at 11:00 A.M. Diagnoses included but were not limited to: "degenerative osteoporosis." The most recent minimum data set assessment, dated 3/6/12, indicated the resident was severely cognitively impaired and required extensive assistance of two staff members for transfers and hygiene. The care plan included a problem, dated 7/1/09 and updated through 6/2012, for "potential for fractures related to osteoporoses." Approaches included "staff to be extra careful during transfers and activities of daily living to avoid possibility of fractures." Another problem, dated 6/29/11 and updated			

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	through 6/12, included "requires full body mechanical lift with 2 assist." Approaches included: "transfer to be provided with full body lift and 2 assist." Another problem, dated 3/15/11 for "potential for impaired skin integrity/pressure ulcer related to ...fragile skin..." Approaches included; "leg sleeves on at all times, do not remove for showers until after transferred to shower chair, skin tears on 4/12 and 4/15/12." 3.1-45(a)(2)			